## PEDIATRIC VISIT 14 TO 16 YEARS

DATE OF SERVICE_____

NAME_____ M / F DATE OF BIRTH_____ AGE_____

WEIGHT_____/_____% HEIGHT_____/_____% BMI _____/_____% TEMP_____ BP_____

### HISTORY REVIEW/UPDATE: *(note changes)*

Medical history updated? Yes / No_____
Family health history updated? Yes / No_____
Reactions to immunizations? Yes / No_____
Concerns: _____

### PSYCHOSOCIAL ASSESSMENT:

**Recent changes in family:** *(circle all that apply)*
New members, separation, chronic illness, death, recent move, loss of job, other_____

**Environment:** Smokers in home? Yes / No

**Violence Assessment:** *(interview separately)*
Any fears of partner/other violence? Yes / No
Access to gun/weapon? Yes / No

### SUBSTANCE ABUSE ASSESS/SCREENING:

**Pos / Neg** For: _____ **Counseled?** Yes / No
**Referral:** Yes / No To:_____

### RISK ASSESSMENT:

| | CHOL | TB | STI/HIV |
|---|---|---|---|
| (Circle) | Pos / Neg | Pos / Neg | Pos / Neg |

### MENTAL HEALTH ASSESSMENT:

Problem identified? Yes / No _____
Counseling provided? Yes / No _____
Referral? Yes / No To: _____

### PHYSICAL EXAMINATION

| Wnl | Abn | *(describe abnormalities)* |
|---|---|---|
| ☐ | ☐ | Appearance/Interaction |
| ☐ | ☐ | Growth (symptoms of eating disorders?) _____ |
| ☐ | ☐ | Skin |
| ☐ | ☐ | Head/Face |
| ☐ | ☐ | Eyes/Red reflex |
| ☐ | ☐ | Cover test/Eye muscles |
| ☐ | ☐ | Ears |
| ☐ | ☐ | Nose |
| ☐ | ☐ | Mouth/Gums/Dentition _____ |
| ☐ | ☐ | Neck/Nodes |
| ☐ | ☐ | Lungs _____ |
| ☐ | ☐ | Heart/Pulses |
| ☐ | ☐ | Chest/Breasts _____ |
| ☐ | ☐ | Abdomen |
| ☐ | ☐ | Genitals/Tanner Stage/Pelvic/GU Age at menarche _____ LMP_____ |
| ☐ | ☐ | Musculoskeletal |
| ☐ | ☐ | Neuro/Reflexes _____ |
| ☐ | ☐ | Vision *(gross assessment)* |
| ☐ | ☐ | Hearing *(gross assessment)* |

### Nutritional Assessment:

**Typical diet** *(specify foods)*:

Symptoms of eating disorder? Yes / No

**Physical Activities:**

At least 1hr. exercise daily? Yes / No

**Education:** Food sources of iron, calcium, folic acid ☐
Select healthy foods ☐ Prevent obesity ☐ Eat breakfast ☐
Avoid eating disorders/fad diets ☐ 2 hrs or less of TV/computer games ☐
5 fruits/vegetables daily ☐ No sweetened beverages ☐

### DEVELOPMENTAL SURVEILLANCE:

**Name of School:** Grade: Performance:

**Peer Relations:**

**Family Relations:**

**Extracurricular activities:**

**Misc. issues:**

### ANTICIPATORY GUIDANCE:

**Social:** Confidentiality ☐ Peer group pressures ☐ Mood swings ☐
Dependence vs. independence ☐ Establishing own values ☐
Social misconduct due to family dysfunctions ☐ Future plans ☐
Stay in school ☐ Love life ☐ ETOH use ☐ Drug Abuse ☐

**Parenting:** Establish fair, negotiable rules ☐ Allow decisions ☐
Provide support, encouragement ☐ Money, allowance ☐
Promote mutual respect ☐ Respect privacy ☐

**Health:** Dental care ☐ Personal hygiene ☐ Fluoride ☐ Menstruation ☐
Breast/testicular self-exam ☐ Smoking ☐ Second hand smoke ☐ Use sunscreen ☐ Tick prevention ☐

**Sexuality:** Prepare for physical changes ☐ Birth control ☐ STDs ☐
Sexual Responsibility ☐

**Injury prevention:** Seat belt ☐ Alcohol/drug use ☐ Bicycle helmets ☐
Protective devices in sports ☐ Water safety ☐
Smoke detector/escape plan ☐ Firearms (owner risk/safe storage) ☐

### PLANS/ORDERS/REFERRALS

1. Review immunizations and bring up to date ☐_____
2. PPD, if positive risk assessment ☐_____
3. Recommend Objective Hearing and Vision Tests ☐_____
4. Testing/counseling if positive cholesterol risk assessment ☐_____
5. Testing if positive STD/HIV risk assessment ☐_____
6. Dental visit advised ☐ or date of last visit_____
7. Next preventive appointment at _____
8. Referrals for identified problems: Yes / No *(specify)*

_____
_____
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**Signatures:**_____